Updates to the RAI Manual Effective October 1, 2018

The annual update to the RAI Manual has been released and contains some substantive changes.

# Section B

B0700: Makes Self Understood: New coding instructions

* This item cannot be coded as Rarely/Never Understood if the resident completed any of the resident interviews, as the interviews are conducted during the look-back period for this item and should be factored in when determining the residents’ ability to make self understood during the entire 7-day look-back period.
* While B0700 and the resident interview items are not directly dependent upon one another, inconsistencies in coding among these items should be evaluated.

# MDS 3.0 Resident Interviews

There are four resident interviews on the MDS 3.0:

* Brief Interview for Mental Status (BIMS): Section C
* Patient Health Questionnaire-9 (PHQ-9) for Mood: Section D
* Interview for Preferences: Section F
* Pain Interview: Section J

The interview for Preferences is required on comprehensive assessments only. It is unique in that the interview may be conducted with a resident’s family or significant other if the resident is not interviewable. Updated coding instructions for this interview are below:

1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
2. Determine whether or not resident is rarely/never understood verbally, in writing, or using another method. If the resident is rarely or never understood, attempt to conduct the interview with a family member or significant other.
3. If resident is rarely/never understood and a family member or significant other is not available, skip to item F0800, Staff Assessment of Daily and Activity Preferences.
4. Conduct the interview during the observation period.
5. Review Language item (A1100) to determine whether or not the resident needs or wants an interpreter. If the resident needs or wants an interpreter, complete the interview with an interpreter.

Instructions for the BIMS interview have been updated to say that this interview is preferred on the ARD or the day before the ARD. It is allowed at any time in the seven day lookback period.

Coding instructions have been updated for the BIMS, PHQ-9 and Pain interviews:

1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
2. Determine if the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to C0700–C1000, Staff Assessment of Mental Status.
3. Review Language item (A1100), to determine if the resident needs or wants an interpreter. If the resident needs or wants an interpreter, complete the interview with an interpreter.

There are unique coding tips for the BIMS, PHQ-9 and Pain interviews as well. These tips apply to stand-alone Other Medicare Required Assessments, so the Preferences Interview would never be on that type of assessment.

* There is one exception to completing the Staff Assessment items in place of the resident interview. This exception is specific to a stand- alone, unscheduled PPS assessment only and is discussed on page 2-60. For this type of assessment only, the resident interview may be conducted up to two calendar days after the ARD.
* When coding a stand-alone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), the interview items may be coded using the responses provided by the resident on a previous assessment only if the DATE of the interview responses from the previous assessment (as documented in item Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in item Z0400) for which those responses will be used.

Identical coding tips also were added for **all** interviews:

* Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
* If the resident needs an interpreter, every effort should be made to have an interpreter present for the [type] interview. If it is not possible for a needed interpreter to be present on the day of the interview, code [gateway question “interview should not be attempted”] to indicate that an interview was not attempted and complete items [staff assessment], includes residents who use American Sign Language (ASL)
* If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item [gateway] must be coded 1, Yes, and the standard “no information” code (a dash “-”) entered in the resident interview items.
* Do not complete the Staff Assessment items if the resident interview should have been conducted but was not done.

# Section GG

A new section, GG0100. Prior Functioning is added to the PPS 5 day assessment. The four categories are:

1. Self-Care: Need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation or injury.
2. Indoor Mobility (Ambulation): Need for assistance walking from room to room (with or without a device such as a cane, crutch, or walker) prior to the current illness, exacerbation or injury.
3. Stairs: Need for assistance with internal or external stairs (with or without a device such as a cane, crutch or walker) prior to the current illness, exacerbation or injury.
4. Functional Cognition: Need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

Coding Instructions:

* Code 3, Independent: if the resident completed the activities by himself or herself, with or without an assistive device, with no assistance from a helper.
* Code 2, Needed Some Help: if the resident needed partial assistance from another person to complete the activities.
* Code 1, Dependent: if the helper completed the activities for the resident, or the assistance of two or more helpers was required for the resident to complete the activities.
* Code 8, Unknown: if the resident’s usual ability prior to the current illness, exacerbation, or injury is unknown.
* Code 9, Not Applicable: if the activities were not applicable to the resident prior to the current illness, exacerbation, or injury.

Coding Tips:

* Record the resident’s usual ability to perform self-care, indoor mobility (ambulation), stairs, and functional cognition prior to the current illness, exacerbation, or injury.
* If no information about the resident’s ability is available after attempts to interview the resident or his or her family and after reviewing the resident’s medical record, code as 8, Unknown.

GGG0110: Prior Device Use: This is also a new section for the PPS 5 day assessment. The assessor is to check all devices the resident used prior to this illness, exacerbation or injury. The devices are manual wheelchair, motorized wheelchair and/or scooter, mechanical lift, walker, orthotics/prosthetics, or none of the above.

Updated instructions for GG0130, Self-Care, and GG0170, Mobility:

* “CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period.”
* New definition: Qualified Clinician - Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.
* There is a new reason code, **code 10, Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints).
* The use of 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s). This is a reversal of the previous instruction that said using the “not attempted” codes” was forbidden in the “Discharge Goal” portion of Section GG.
* Reason code 09, “Not applicable,” is not a new code, but there is a change in the definition: “Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.”

GG0130: Self Care

There are new additions to some ADL definitions:

Eating:

* Assesses eating and drinking by mouth only
* Assistance with tube feedings or TPN is not considered when coding the Eating item. If some PO and some enteral/parenteral, code assistance with PO only.
* If the resident eats finger foods with his or her hands, code based upon the amount of assistance provided.

Oral Hygiene: New coding tip: If a resident does not perform oral hygiene during therapy, determine the resident’s abilities based on performance on the nursing care unit.

Toileting Hygiene: Includes the tasks of managing undergarments, clothing, and incontinence products, and performing perineal cleansing before and after voiding or having a bowel movement

* Can take place before and after use of the toilet, commode, bedpan, or urinal
* If the resident does not usually use undergarments, then assess the resident’s need for assistance to manage lower-body clothing and perineal hygiene
* If the resident has an indwelling urinary catheter and has bowel movements, code the toileting hygiene item based on the amount of assistance needed by the resident when moving his or her bowels

New ADL Activities added:

Shower/bathe self: Includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area, and feet. Assessment of shower/bathe self can take place in a shower or bath, at a sink, or at the bedside (i.e., sponge bath).

Upper body dressing: The ability to dress and undress above the waist; including fasteners; if applicable.

Lower body dressing: The ability to dress and undress below the waist; including fasteners; if applicable.

Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Coding tips:

* Helper assistance with buttons and/or fasteners is considered touching assistance.
* If donning and doffing an elastic bandage, elastic stockings, or an orthosis or prosthesis occurs while dressing/undressing, then count the item as a piece of clothing.
* Upper body dressing can’t be based solely on donning/doffing hospital gown.
* Footwear on bilateral lower extremity prostheses does not count in “putting on/taking of footwear.” Code appropriate “Did not occur” code.
* For residents with a single lower extremity amputation with or without use of a prosthesis, the activity of putting on/taking off footwear could apply to the intact limb or both the limb with the prosthesis and the intact limb.

GG0170: Mobility items added:

Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed.

Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.

Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.

1 step (curb): the ability to go up and down a curb and/or up and down one step.

4 steps: The ability to go up and down four steps with or without a rail.

12 steps: The ability to go up and down 12 steps with or without a rail.

Coding Tips:

* Walking activities do not need to occur during one session. Allowing a resident to rest between activities or completing activities at different times during the day or on different days may facilitate completion of the activities.
* When coding walking items, do not consider the resident’s mobility performance when using parallel bars. Parallel bars are not a portable assistive device. If safe, assess and code walking using a portable walking device.
* Wheelchair Mobility: Some coding tips were added and/or reworded:
* Do not code wheelchair mobility if the resident uses a wheelchair only when transported between locations within the facility or for staff convenience
* Only code wheelchair mobility based on an assessment of the resident’s ability to mobilize in the wheelchair.
* If the resident walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility, code the wheelchair gateway items as 0, No, and skip all remaining wheelchair questions.
* Admission assessment for wheelchair items should be coded for residents who used a wheelchair prior to admission.
* The responses for gateway admission and discharge wheelchair items do not have to be the same on the Admission and Discharge assessments

The general coding guidelines for Section GG were overhauled in many places but did not represent a change in guidance, except what was mentioned above.

# Section I

Section I0020A**: Indicate the resident’s primary medical condition category**

This is a new section to fulfill requirements for the Skilled Nursing Facility Quality Reporting Program (SNF-QRP). It will be on a PPS 5 day assessment only and will be used to set risk factors for some new SNF-QRP quality measures that will begin collection October 1st.

The primary medical condition coded in I0020A must also be coded in Section I0100 – I0800. Categories are:

* Code 1, Stroke: Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease
* Code 02, Non - traumatic Brain Dysfunction: Examples include Alzheimer’s disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, and anoxic brain damage.
* Code 03, Traumatic Brain Dysfunction: Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.
* Code 04, Non-traumatic Spinal Cord Dysfunction: Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta.
* Code 05, Traumatic Spinal Cord Dysfunction: Examples include paraplegia and quadriplegia following trauma.
* Code 06, Progressive Neurological Conditions: Examples include multiple sclerosis and Parkinson’s disease.
* Code 07, Other Neurological Conditions: Examples include cerebral palsy, polyneuropathy, and myasthenia gravis
* Code 08, Amputation: For example, acquired absence of limb.
* Code 09, Hip and Knee Replacement: For example, total knee replacement. If hip replacement is secondary to hip fracture, code as fracture.
* Code 10, Fractures and Other Multiple Trauma: Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.
* Code 11, Other Orthopedic Conditions: For example, unspecified disorders of joint.
* Code 12, Debility, Cardiorespiratory Conditions: Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue.
* Code 13, Medically Complex Conditions: Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.
* Code 14, Other Medical Condition: If the resident’s primary medical condition category is not one of the listed categories, enter the International Classification of Diseases (ICD) code, including the decimal, in I0200A. If Item I0020 is coded 1 through 13, do not complete I0020A.

Section I5100: **Quadriplegia,** new guidance:

* Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury.
* Coding I5100 Quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition.
* Functional quadriplegia refers to complete immobility due to severe physical disability or frailty. Conditions such as cerebral palsy, stroke, contractures, brain disease, advanced dementia, etc. can also cause functional paralysis that may extend to all limbs hence, the diagnosis functional quadriplegia. For individuals with these types of severe physical disabilities, where there is minimal ability for purposeful movement, their primary physician-documented diagnosis should be coded on the MDS and not the resulting paralysis or paresis from that condition. For example, an individual with cerebral palsy with spastic quadriplegia should be coded in I4400 Cerebral Palsy, and not in I5100, Quadriplegia.

# Section J2000: Prior Surgery

This section will be on a PPS 5 day assessment only, for calculation of SNF-QRP risk adjustments. It is a question: “Did the resident have major surgery during the 100 days prior to admission?” Generally, a major surgery for Item J2000 refers to a procedure that meets all the following criteria:

1. Resident was inpatient in acute care hospital for at least 1 day in the 100 days prior to admission to the SNF.
2. Resident had general anesthesia.
3. Surgery carried some degree of risk to the resident’s life or the potential for severe disability.

# Section K: K0510: Nutritional Approaches and K0710: Percent intake by Artificial Route

CMS has made certain blocks in these sections optional, unless the state requires them:

* K0510C1: Mechanically altered diet, while not a resident.
* K0510D1: Therapeutic diet, while not a resident.
* K0710A1: Proportion of total calories the resident received through parenteral or tube feeding, while not a resident.
* K0710B1: Average fluid intake per day by IV or tube feeding, while not a resident.

# Section M: Skin Conditions

Five sections have been removed:

* **M0300B3.** Date of oldest Stage 2 pressure ulcer
* **M0610.** Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar.
* **M0700.** Most Severe Tissue Type for Any Pressure Ulcer.
* **M0800** Worsening in Pressure Ulcer Status Since Prior Assessment (Omnibus Budget Reconciliation Act (OBRA) or Scheduled PPS).
* **M0900:** Healed Pressure Ulcers.

All references to “pressure ulcers” are now “pressure injuries,” and the term “suspected” has been removed from “deep tissue injury.”

# Section N: Drug Regimen Review

N2001 and N2003 will be on the PPS 5 day assessment. N2005 will be on the Part A PPS Discharge. This section will be used to calculate a SNF-QRP quality measure that will begin collection October 1st. It requires the SNF to respond when a drug regimen review identifies potentially clinically significant medication issues upon admission and throughout the Part A stay. There is a question that must be answered: “Did the facility contact a physician (or physician designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues? And, upon discharge from Part A the question is for the entire stay, asking if this action was taken each time a clinically significant issues was identified. If there was no drug regimen review, the items must be coded with a dash (-).

A drug regimen review includes medication reconciliation, a review of all medications a resident is currently using, and a review of the drug regimen to identify, and if possible, prevent potential clinically significant medication adverse consequences. The drug regimen review includes all medications, prescribed and over the counter (OTC), nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. It also includes total parenteral nutrition (TPN) and oxygen.

A clinically significant medication issue is a potential or actual issue that, in the clinician’s professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest. “Clinically significant” means effects, results, or consequences that materially affect or are likely to affect an individual’s mental, physical, or psychosocial well-being, either positively, by preventing a condition or reducing a risk, or negatively, by exacerbating, causing, or contributing to a symptom, illness, or decline in status. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the drug regimen review items.

Clinically significant medication issues include, but are not limited to:

* Medication prescribed despite documented medication allergy or prior adverse reaction
* Excessive or inadequate dose
* Adverse reactions to medication
* Ineffective drug therapy
* Drug interactions
* Duplicate therapy
* Wrong resident, drug, dose, route, and time errors
* Medication dose, frequency, route, or duration not consistent with resident’s condition, manufacturer’s instructions, or applicable standards of practice
* Use of a medication without evidence of adequate indication for use
* Presence of a medical condition that may warrant medication therapy (e.g., a resident with primary hypertension does not have an antihypertensive medication prescribed)
* Omissions (medications missing from a prescribed regimen)
* Nonadherence (purposeful or accidental)

“Contact with the physician”:

* Communication with the physician to convey an identified potential or actual clinically significant medication issue, and a response from the physician to convey prescribed/recommended actions in response to the medication issue.
* Communication can be in person, by telephone, voice mail, electronic means, facsimile, or any other means that appropriately conveys the resident’s status.

Coding Tips:

If MD prescribes action that will take longer than midnight of the next calendar day to complete, then code 1, Yes, should still be entered, if by midnight of the next calendar day, the clinician has taken the appropriate steps to comply with the recommended action.

* Example of a physician-recommended action that would take longer than midnight of the next calendar day to complete:
	+ The physician writes an order instructing the clinician to monitor the medication issue over the next three days & call if the problem persists.

# Section O0100A: Chemotherapy

Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should not be coded in this item, as they are not considered chemotherapy for the purpose of coding the MDS. One example of this type of drug that would not count here is tamoxifen.

# Section O0100F: Invasive Mechanical Ventilator

Updated definition: Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) unable to support his or her own respiration in this item. During invasive mechanical ventilation the resident’s breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy. A resident who has been weaned off of a respirator or ventilator in the last 14 days, or is currently being weaned off a respirator or ventilator, should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

# Section O0100G: Non-invasive Mechanical Ventilator

Updated definition: Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to support his or her own spontaneous respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that “breathe” for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask/device.

# Section O0300: Pneumococcal Vaccine

Coding instructions are reworked to include current recommendations for pneumococcal vaccines. Updated sections below:

If pneumococcal vaccination status cannot be determined, administer the recommended vaccine(s) to the resident, according to the standards of clinical practice.

* If the resident has had a severe allergic reaction to a pneumococcal vaccine or its components, the vaccine should not be administered.
* If the resident has a moderate to severe acute illness, the vaccine should be administered after the illness.
* If the resident has a minor illness (e.g., a cold) check with the resident’s physician before administering the vaccine.
* Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf.
* “Up to date” in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.
* For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at
	+ https://www.cdc.gov/vaccines/schedules/hcp/index.html
	+ http://www.cdc.gov/vaccines/hcp/acip-recs/index.html
	+ https://www.cdc.gov/pneumococcal/vaccination.html
* If a resident has received one or more pneumococcal vaccinations and is indicated to get an additional pneumococcal vaccination but is not yet eligible for the next vaccination because the recommended time interval between vaccines has not lapsed, O0300A is coded 1, yes, indicating the resident’s pneumococcal vaccination is up to date.

There are several examples added to clarify the coding guidelines.

Finally, many of the Care Area Assessment Review of Indicators in Appendix C were updated.